

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6425

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film G217 6-28-57 et

Reg. Dist. No.

06406

201

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETTERTON</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 Betterton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>LEWIS</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>		12. BIRTHPLACE (State or foreign country) <u>Delaware</u>		13. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		14. FATHER'S NAME <u>John Taylor Bennett</u>	
15. MOTHER'S MAIDEN NAME <u>Annie B. Hambo</u>		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>161-03-5147</u>		18. INFORMANT <u>Mary Bennett (wife)</u>	
19. ADDRESS <u>Betterton, Md.</u>		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable congestive heart failure</u> 527.1 DUE TO (b) <u>Pulmonary emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>540.0</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peptic ulcer - probable coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Several years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GRACELAWN MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>WILMINGTON DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor H. Kennedy</u>		ADDRESS <u>STILL BOND, MD.</u>		24a. REC'D BY REGISTRAR <u>6/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>	

DATE SIGNED

6/13/57

RECEIVED

JUN 25 1957

BUREAU V. S.

BRITAIN 8-17-57  
STILL FORD, MD

101-03-2143

No

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06407

6426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>41 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. STREET ADDRESS <b>/ Rural</b>	
3. NAME OF DECEASED (Type or print) <b>Ada Elizabeth Grussing</b>		4. DATE OF DEATH <b>June 27, 1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1882</b>
9. AGE (In years and birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Howard Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>George Grussing</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> <b>442X</b> DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>4 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> , 19 <b>June 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>57</b> , and that death occurred at <b>6:15 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. C. Dick</b> M.D.		ADDRESS (Street, city or town, state) <b>6-29-57</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>A. C. Dick - Chestertown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Wells</b> ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 2 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Christa Baney</b>			

BUREAU V. S.

2 JUL 1957

RECEIVED

6427

## CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Georgg</b> Middle <b>V.</b> Last <b>Hatcherson</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1878</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>		11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert R. Hatcherson</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-36-1695 A</b>		17. INFORMANT <b>Robert R. Hatcherson</b>		Address <b>Chestertown Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 443X DUE TO <b>Hypertension Cardio Vascular.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) <b>Neurophlegia</b> 352X						INTERVAL BETWEEN ONSET AND DEATH <b>Autism</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>352X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Rock Hall, Md.</b>	(County) <b>Rock Hall, Md.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>June 1, 1957</b> , to <b>June 13, 1957</b> , that I last saw the deceased alive on <b>June 10, 1957</b> , and that death occurred at <b>9:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b> DATE SIGNED <b>June 13, 1957</b>							
ACTUAL SIGNATURE <b>Norbert C. Nitsch</b>		M.D. <b>Rock Hall, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Norbert C. Nitsch</b>		<b>- Rock Hall, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>	<b>June 16, 1957</b>	<b>St. Paul Cem.</b>		<b>nr. Chestertown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 17 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Charles B. Jones</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6428

CERTIFICATE OF DEATH

06409

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Worton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Carter Jones				4. DATE OF DEATH Month Day Year June 16 19 57			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1 1890	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) storekeeping		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Worton Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. David Carter				14. MOTHER'S MAIDEN NAME Mary Eliz. Rasin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-32-9717		17. INFORMANT Address Mrs. John M. Clayton Worton Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 remia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.3 (b) hypertensive renal disease DUE TO (c) hypertension INTERVAL BETWEEN ONSET AND DEATH 6 weeks 5 years ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cardiac Decompensation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1954, to June 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 7 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Florence Deringer Joyce M.D.				ADDRESS (Street, city or town, state) Worton		DATE SIGNED Jul 14/57	
PHYSICIAN'S NAME (Type) Florence Deringer Joyce				Worton Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18/57		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Marvin V. Williams Chestertown, Md.				24a. REC'D BY REGISTRAR DATE June 18-57		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John W. Glick</i>		DATE OF DEATH <i>June 19 1957</i>	
AGE <i>68</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>General</i>		MANNER OF DEATH <i>Natural</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
COUNTY <i>Harford</i>		STATE <i>Maryland</i>	
DATE OF BIRTH <i>May 1 1889</i>		PLACE OF BIRTH <i>Germany</i>	
MARRIAGE <i>Married</i>		SPOUSE <i>Married</i>	
PREVIOUS ILLNESS <i>None</i>		CAUSE OF DEATH <i>Heart Disease</i>	
IMMEDIATE CAUSE <i>Heart Disease</i>		MEDICAL OPINION <i>Heart Disease</i>	
SIGNATURE OF PHYSICIAN <i>John W. Glick</i>		SIGNATURE OF DECEASED <i>John W. Glick</i>	
DATE OF SIGNATURE <i>June 19 1957</i>		DATE OF SIGNATURE <i>June 19 1957</i>	

BUREAU V. E.

JUN 20 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6429  
CERTIFICATE OF DEATH

06410  
202

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/Chestertown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		d. STREET ADDRESS <b>R ural</b>	
3. NAME OF DECEASED (Type or print) <b>Philip L. Leager</b>		4. DATE OF DEATH <b>June 28, 1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1909</b>
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alonza Leager</b>		14. MOTHER'S MAIDEN NAME <b>Sidney Trimble</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>YES</b>	
17. INFORMANT <b>Mrs. Philip Leager</b>		Address <b>Chestertown, Md. Rural</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/27</b> , 19 <b>57</b> , to <b>6/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/28</b> , 19 <b>57</b> , and that death occurred at <b>8:30</b> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6-29-57</b>			
ACTUAL SIGNATURE <b>Robert W. Farr</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert W. Farr Chestertown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Wells</b>		24a. REC'D BY REGISTRAR <b>JUL 2 1957</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Barnes</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

JUL 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6418

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06411  
207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN life <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert St.</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b> d. STREET ADDRESS <b>Calvert St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willie Wm. Lively (or) Lindsey</b>		4. DATE OF DEATH <b>June 18, 1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1902</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi Lively</b>		14. MOTHER'S MAIDEN NAME <b>Louise Lindsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-16-7101</b>	
17. INFORMANT <b>Viola Foreman</b>		Address <b>436 Moorehouse Drive Wilmington - Dela.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Natural Causes - unknown</b> DUE TO <b>No history of physical ailment obtainable.</b> Conditions, if any, which gave rise to immediate cause (b) <b>Deceased had been working <del>INEXHAUSTIVELY</del> every day and had been observed to have been drinking heavily the day before. He was found dead on the stairway of his home the morning of June 18, 1957. There was no sign of injury.</b> DUE TO (c) <b>less than 2 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONCERNING DEATH <b>INTERVAL BETWEEN ONSET AND DEATH</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Robert W. Farr</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>June 20 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pomona Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near Chestertown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Barnes</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME	LAST	FIRST	MIDDLE
CHAPMAN	JOHN	WILLIAM	EDWARD
AGE	SEX	RACE	RELIGION
45	M	W	R
DATE OF BIRTH	PLACE OF BIRTH	CITY	STATE
1912	NEW YORK	NEW YORK	NEW YORK
DATE OF DEATH	PLACE OF DEATH	CITY	STATE
1957	NEW YORK	NEW YORK	NEW YORK
DATE OF EXAMINATION	PLACE OF EXAMINATION	CITY	STATE
1957	NEW YORK	NEW YORK	NEW YORK
DATE OF BURIAL	PLACE OF BURIAL	CITY	STATE
1957	NEW YORK	NEW YORK	NEW YORK

History of Present Illness: The patient had been in good health until about one month prior to the onset of the present illness. He had been feeling increasingly tired and had lost weight. He had been unable to work for the past month. He had been in the hospital for the past two weeks. He had been given various treatments, including antibiotics, but had not improved. He had been in the hospital for the past two weeks. He had been given various treatments, including antibiotics, but had not improved. He had been in the hospital for the past two weeks. He had been given various treatments, including antibiotics, but had not improved.

BUREAU V. S.

JUN 21 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06412

6419

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>Harlan</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland 55x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hosp.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>L.</b> Last <b>Livingston</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19 1884</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mining</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Livingston</b>		14. MOTHER'S MAIDEN NAME <b>Cora LLOYD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>400-09-4230</b>	
17. INFORMANT <b>Mrs. Ann Livingston</b>		Address <b>Cumberland Kentucky</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>526x Bronchiectasis, emphysema</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. _____ Month, Day, Year _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>57</b> , to <b>June 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>57</b> , and that death occurred at <b>2:30</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Rock Hall, Md 6/10/57</b>	
PHYSICIAN'S NAME (Type) <b>Willard Smith</b>		<b>Rock Hall, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cumberland</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Kentucky</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b>		ADDRESS <b>Chestertown, Md</b>	
24a. REC'D BY REGISTRAR <b>June 12-1957</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text: ...]</p>		<p>2. SEX                  [Faint text: ...]</p>	
<p>3. AGE                  [Faint text: ...]</p>		<p>4. DATE OF DEATH                  [Faint text: ...]</p>	
<p>5. PLACE OF DEATH                  [Faint text: ...]</p>		<p>6. CAUSE OF DEATH                  [Faint text: ...]</p>	
<p>7. MANNER OF DEATH                  [Faint text: ...]</p>		<p>8. SIGNATURE OF DECEASED                  [Faint text: ...]</p>	
<p>9. SIGNATURE OF WITNESS                  [Faint text: ...]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [Faint text: ...]</p>	
<p>11. SIGNATURE OF CLERK                  [Faint text: ...]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint text: ...]</p>	

BUREAU V. 2

JUN 14 1967

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may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 Patient has been a recent inmate of the Veterans Hospital at PerryPoint, Md. and was home on leave when he became ill and shortly died. Diagnosis based on data obtained when patient was last seen.

# STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18 6430 Items 8,9 Film G216 6-14-57 et CERTIFICATE OF DEATH

06413

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Kennedyville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest</b> <b>Tharon</b> <b>Manley</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1907</b>		9. AGE (In years last birthday) <b>50</b> yrs.	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Manley</b>				14. MOTHER'S MAIDEN NAME <b>Eva C. Cubank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-11</b>		17. INFORMANT <b>Mrs. Mary Manley - Kennedyville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO <b>HIGX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Old rheumatic heart disease</b> DUE TO (c) <b>Many years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-21</b> , 19 <b>56</b> , to <b>11-27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-27</b> , 19 <b>56</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>11-27</b>							
ACTUAL SIGNATURE <b>A.C. Dick</b>				M.D. <b>11-27</b>			
PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 4</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DOUBLE CREEK</b>		22d. LOCATION (City, town, or county) (State) <b>MCGINNESS CORNER MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar H. Lane</b>				ADDRESS <b>Church Hill</b>		24a. RECEIVED BY REGISTRAR <b>JUNE 6 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>E. Lane</b>	

# CERTIFICATE OF DEATH

IRVING L. B. STATE DEPARTMENT OF HEALTH - BALTIMORE 11

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED WAS A RESIDENT OF THE CITY OF BALTIMORE, MARYLAND, AT THE TIME OF HIS DEATH.

BUREAU V. S.

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18&amp;20 Film 217 7-5-57 ams

## CERTIFICATE OF DEATH

Reg. Dist. No.

06414

201

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH DISHINGTON REID</u>		4. DATE OF DEATH Month Day Year <u>JUNE 21 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 18 1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		9b. AGE (In years last birthday) <u>61</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>	
13. FATHER'S NAME <u>THOMAS DISHINGTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>GREAT BRITAIN</u>	
14. MOTHER'S MAIDEN NAME <u>JANE COCHBURN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. BETTY CALLOWAY, MILLINGTON MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degeneration of the heart muscle</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Fracture of the hip bone</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>One week</u> <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis - Decubitus -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient slipped while walking in her room.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5/18/ 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>904.0</u>	
21. I certify that I attended the deceased from <u>May 18</u> , 19 <u>57</u> , to <u>June 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>57</u> , and that death occurred at <u>7:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geza Koralewski</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>MILLINGTON G. 21.57</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER FIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CHESTERVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>CHURCH HILL, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>E. Howard Jones</u>	

CERTIFICATE OF DEATH

AND CAUSE

DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

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JUN 26 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 0217 7-1-57 et

6432

## CERTIFICATE OF DEATH

06415

Reg. Dist. No.

203

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>---</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA L SAPPINGTON</u>				4. DATE OF DEATH Month Day Year <u>JUNE 22 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1869 OCT 16, 1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN F. SAPPINGTON</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE WICKES.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>FRANKLIN WOOD. ROCK HALL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis, Cardio Vascular</u> DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>794X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 20, 1957</u> , to <u>June 22, 1957</u> , that I last saw the deceased alive on <u>June 22, 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C Nitsch</u> M.D.				ADDRESS (Street, city or town, state) <u>Rock Hall</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT C NITSCH</u>				DATE SIGNED <u>June 24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>JUNE 25</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>ROCK HALL Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edgar L. Lawrence Church Hill</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edmond Burgess</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

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JUN 26 1957  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06416

6420

## CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Che stertown 37</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's Hosp.</b>		d. STREET ADDRESS <b>Mill Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Rebecca Shinn</b>		4. DATE OF DEATH Month Day Year <b>June 25, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1878</b>
9. AGE (In years birthday) yrs. <b>79</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Victor Hendrickson</b>		14. MOTHER'S MAIDEN NAME <b>Sally Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-34-3647</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Cardio-vascular-renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>7 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 50</b> to <b>June 25 57</b> , that I last saw the deceased alive on <b>June 25 19 57</b> , and that death occurred at <b>10 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>6-25-57</b>			
ACTUAL SIGNATURE <b>A2C. Dick.</b>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 28, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll H. Hines</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race	
John and Susan Anna's name		Male		4 days		Caucasian	
Place of Birth		Married		Date of Death		Cause of Death	
Kent		Male		June 22, 1957		Stillborn	
Place of Death		Occupation		Date of Burial		Place of Burial	
Chesapeake		Shipman		June 23, 1957		St. John's Church	
Signature of Physician		Signature of Registrar		Date of Registration		Place of Registration	
[Signature]		[Signature]		June 23, 1957		Baltimore, MD	
Name of Physician		Name of Registrar		Date of Registration		Place of Registration	
Victor Handrickson		[Signature]		June 23, 1957		Baltimore, MD	
Name of Hospital		Name of Registrar		Date of Registration		Place of Registration	
[Name]		[Signature]		June 23, 1957		Baltimore, MD	
Name of Hospital		Name of Registrar		Date of Registration		Place of Registration	
[Name]		[Signature]		June 23, 1957		Baltimore, MD	

BUREAU V. 3

JUN 28 1957

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Name of Registrar		Date of Registration		Place of Registration	
[Signature]		June 23, 1957		Baltimore, MD	

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72  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06417

6421

## CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <u>KENT.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>KENT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 ROCK HALL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>KENT &amp; QUEEN ANNE'S HOSP</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PATRICIA E. SMITHSON</u>			4. DATE OF DEATH Month Day Year <u>JUN 14 1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 28, 1943</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CHARLES D. SMITHSON</u>			14. MOTHER'S MAIDEN NAME <u>ETHEL RUDNEY</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HOSP. CHART.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS, generalized</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Ovary</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APR 1</u> , 19 <u>57</u> , to <u>JUN 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUN 12, 1957</u> , and that death occurred at <u>11<sup>02</sup></u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. J. Keefe</u> M.D. <u>CHESTERTOWN, Md. 6-14-57</u> PHYSICIAN'S NAME (Type) <u>A. J. KEEFE JR. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>6/17/57</u>		<u>St Johns</u>		<u>Rock Hall, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill</u>				24a. REC'D BY REGISTRAR <u>JUN 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Baranov</u>	



# CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
SM 9/55

6433

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06418

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY <u>KENT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL (Kent) Life -</u> c. LENGTH OF STAY IN 1b <u>x2 Rock Hall</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>FANNIE MARLIN VANSANT</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Gleason</u>			14. MOTHER'S MAIDEN NAME <u>Jory</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Chas S. Vansant, Rock Hall, Md. funeral</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable coronary thrombosis</u> <u>420.1</u> DUE TO <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterial hypertension</u> <u>several years</u> DUE TO (c) <u>  </u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447x</u>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/15/57</u>		
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL</u>		
22d. LOCATION (City, town, or county) <u>Rock Hall, MD.</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lamm</u>		ADDRESS <u>CHURCH HILL, MD.</u>		24a. REC'D BY REGISTRAR <u>JUN 19 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>E. Burgess</u>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1957

RECEIVED

6422

CERTIFICATE OF DEATH

06419

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. LENGTH OF STAY IN 1b <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes Hospital</b>				d. STREET ADDRESS <b>118 Front Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Vinyard</b>				4. DATE OF DEATH Month Day Year <b>June 21 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1907</b>		9. AGE (In years last birthday) yrs. <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herman W. Vinyard</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/18/57</b> , 19 <b>57</b> , to <b>6/21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/21</b> , 19 <b>57</b> , and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>6/21/57</b>							
ACTUAL SIGNATURE <b>A. C. Dick</b> M.D.				PHYSICIAN'S NAME (Type) <b>A. C. Dick</b> <b>Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Barratt's Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Berry Jr., Prilford, Del.</b>				24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. ...</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. HARRIS		AGE 45 years		SEX Male	
RACE White		EDUCATION High School		OCCUPATION Carpenter	
MARRIAGE Married		DATE OF MARRIAGE Jan 15, 1910		PLACE OF BIRTH New York City	
PLACE OF DEATH 118 First Street		DATE OF DEATH June 28, 1957		CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural		CERTIFICATE OF DEATH Issued by		SIGNATURE OF REGISTRAR [Signature]	
DATE OF REGISTRATION June 28, 1957		PLACE OF REGISTRATION Baltimore, Md.		OFFICIAL USE	

BUREAU V. A.

JUN 28 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE, 18

06420

6423

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Frank</b> Last <b>Willis</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1894</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Willis</b>		14. MOTHER'S MAIDEN NAME <b>Willie Legg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of abdominal aortic aneurysm</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>451X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>53</b> , to <b>June 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 13</b> , 19 <b>57</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/14/57</b>			
ACTUAL SIGNATURE <b>Willard F. Smith</b>		M.D. <b>Rock Hall, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. RECEIVED BY REGISTRAR <b>JUN 17 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Clara B. Bess</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
HARRY FRANK		JULY 12, 1957	
AGE		SEX	
35		Male	
RACE		PLACE OF BIRTH	
White		Maryland	
OCCUPATION		CAUSE OF DEATH	
None		Heart Disease	
MANNER OF DEATH		PLACE OF DEATH	
Natural		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		TIME	
JULY 12, 1957		10:00 AM	
LOCALITY		COUNTY	
Baltimore		Baltimore	
STATE		FEDERAL DISTRICT	
Maryland		District of Columbia	

BUREAU V. S.

JUN 17 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>KENT, QUEEN ANNE'S HOSP</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BETTY JEAN WILMER</b>				4. DATE OF DEATH Month Day Year <b>JUN 13 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 8, 1941</b>	9. AGE (In years last birthday) <b>15</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STUDENT</b>		11. BIRTHPLACE (State or foreign country) <b>CHESTERTOWN, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES WILMER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA JOHNSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT Address <b>HOSPITAL CHART.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FRACTURED LIVER Auto accident</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>AUTOMOBILE ACCIDENT.</b>			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>JUN 11 1957</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>ROAD</b>	
				20f. (City or town) <b>QUEEN ANNE MD.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>JUN 11, 1957</b> , to <b>JUN 13, 1957</b> , that I last saw the deceased alive on <b>JUN 13, 1957</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, MD</b> DATE SIGNED <b>6-13-57</b>							
ACTUAL SIGNATURE <b>A. T. KEEFE, JR.</b> M.D.				DATE SIGNED <b>6-13-57</b>			
PHYSICIAN'S NAME (Type) <b>A. T. KEEFE, JR.</b>				DATE SIGNED <b>6-13-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Col. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Wells</b>				24a. REC'D BY REGISTRAR <b>JUN 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Barnes</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6434

## CERTIFICATE OF DEATH

06422

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>		c. LENGTH OF STAY IN 1b <b>30 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>CHRISTIAN</b> Last <b>WITT</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 25, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOAT CAPTAIN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WATERMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIE F. WITT</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA WITT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-32-8925</b>	
17. INFORMANT <b>MRS. EOLIN D. WITT, ROCK HALL MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Hypertension - Cardiovascular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Oedema of both extremities</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1 - 1956</b> , to <b>June 18, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Norbert C Nitsch</b> M.D. <b>Rock Hall, June 20, 1957</b> PHYSICIAN'S NAME (Type) <b>NORBERT C NITSCH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 21, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WESLEY CHAPEL</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lamm</b>		24a. REC'D BY REGISTRAR <b>June 24 1957</b>	
ADDRESS <b>CHURCH HILL</b>		24b. REGISTRAR'S SIGNATURE <b>Edward Burgess</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1912		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
JUN 16 1957		NEW YORK		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
JUN 16 1957		JUN 16 1957		JUN 16 1957		JUN 16 1957		JUN 16 1957		JUN 16 1957	

RECEIVED  
JUN 24 1957  
BUREAU V. S.